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Final Report of the Task Force on Improving Access to Prescription Drugs for the Elderly, 1998

Maine State Legislature

Office of Policy and Legal Analysis

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STATE OF MAINE
118TH LEGISLATURE
FIRST REGULAR AND FIRST SPECIAL SESSIONS

Final Report of the TASK FORCE ON IMPROVING ACCESS TO PRESCRIPTION DRUGS FOR THE ELDERLY

February 17, 1998

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Executive Summary

The Task Force on Improving Prescription Drugs for the Elderly was created by Public Law 1997, Chapter 560, Part E. Its charge was direct: To determine and recommend methods of improving access to prescription drugs for the elderly.

The Task Force met four times, and relied greatly on information provided by the Department of Human Services, Bureau of Medical Services on population, drug usage and program utilization rate estimates and projections.

The Task Force makes four recommendations:

1. Improve the public education and outreach efforts for the current Elderly Low-cost Drug Program;

2. Direct the Department of Human Services to seek a Medicaid waiver from the Health Care Financing Administration to provide Medicaid prescription drug benefits for persons 62 years of age and over, whose income is up to 185% of the federal poverty level. The recommendation is flexible concerning the exact percentage of the federal poverty level in order to approximate cost neutrality achieved through the decrease in institutionalization costs resulting from greater access to prescription drugs for the elderly;

3. Until the waiver is granted and the program under it takes effect, expand the existing Elderly Low-cost Drug Program by increasing the income ceiling to 185% of the federal poverty level. Because this recommendation was arrived at before all the estimates and projections were available from the Bureau of Medical Services, the Task Force may support an adjustment in this income level and a shift to include additional medications if the benefits are greater as indicated by the new information; and

4. Request that the Joint Standing Committee on Banking and Insurance, the Joint Standing Committee on Health and Human Services and the Bureau of Insurance work together to develop methods of providing financial assistance or insurance coverage for prescription drugs for organ transplant patients in this State.

I Introduction

A. Inception of the study

During the First Regular and First Special Sessions of the 118th Legislature, the Legislature and the Governor wrestled with issues concerning taxes on tobacco products, improving the health of Maine citizens and whether and how those issues should be connected. Although much of the discussion and drafting centered in the Joint Standing Committee on Health and Human Services, there was considerable floor debate as well. Interim proposals concerning the prescription drugs for the elderly program included an expansion of the existing program to extend Medicaid prescription drug coverage to elder adults meeting age and income criteria (LD 1887, vetoed by the Governor). When the Legislature finally adjourned, Public Law 1997, Chapter 560 (LD 1904) created the Task Force on Improving Access to Prescription Drugs for the Elderly.

B. Task Force on Improving Access to Prescription Drugs for the Elderly

The Task Force on Improving Access to Prescription Drugs for the Elderly was created in Public Law 1997, Chapter 560, Part E. (See Appendix A.) The Task Force consists of nine members, three each appointed by the President of the Senate, the Speaker of the House of Representatives and the Governor. The three appointing authorities were required to jointly select the Task Force Chair from the members. Senator Chellie Pingree was selected as chair. See Appendix B for the list of members.

Although the effective date of Part E of Chapter 560 was September 19, 1997 and the legislation required the first meeting to be convened no later than October 10, 1997, because the appointment process was delayed, the Task Force did not begin meeting until December 4, 1997. Chapter 560 established the reporting date for the Task Force's report and legislative recommendations as January 15, 1998. The Legislative Council extended that reporting date to February 13, 1998.

The charge to the Task Force is direct: To determine and recommend methods on improving access to prescription drugs for the State's elderly citizens.

C. Study process

One of the first questions the Task Force faced was what does "improving access" mean? There was some discussion as to whether elderly citizens can adequately access prescription drugs under the current program. Another question faced by the Task Force was what is the program lacking? One concern is that the State is missing an opportunity to provide medication crucial to keeping a large segment of the older population in the workforce by not including more illnesses, conditions and medications in the program. If illnesses and conditions are treated earlier, better health and greater savings can be enjoyed

in the future. An evaluation of New York State's EPIC program found significant savings in acute care and institutionalization costs resulting from better access to prescription drugs for the older population. (EPIC Evaluation Report to the Governor and Legislature: Maintaining Health, Dignity and Independence, 1987-1995)

The Task Force heard about specific and general inadequacies of the current program. For example, anti-rejection drugs needed by organ transplant patients are not covered by the Elderly Low-cost Drug Program or Medicare. There is apparently no practical insurance coverage available in Maine for organ transplant patients, whose prescription drugs bills run as high as $2,000 per month. A social worker with the Maine Medical Center informed the Task Force that more transplants were being provided to more people, and that more recipients are in their 60s and 70s than ever before. This means a greater number of people will have extremely high prescription drug costs with very few avenues of assistance open to them unless they are indigent. (Medicaid and some drug manufacturers' programs provide coverage or assistance to low income transplant patients.) Another social worker from the Maine Medical Center explained the difficult choices that many people face when their resources are insufficient to cover both medications and other necessities.

The Task Force discussed several ways that the current program could be changed to improve access:

- Better utilization of the current program, aided through better public education and outreach about the availability of the program
- Expand eligibility for the program
    - Increasing the income limitations
    - Lowering the minimum age
- Expand the diagnoses -- and, hence, the medications -- covered

The Task Force requested the Department of Human Services, Bureau of Medical Services to estimate the costs of improving access through the implementation of each option. The members developed their recommendations with deference to what is realistic in terms of new costs to the State and the likelihood of additional funding from the federal government.

Special thanks to Francis Finnegan and Robert Carroll of the Bureau of Medical Services for crucial assistance in providing the Task Force with information about the Elderly Low-cost Drug Program and projected costs and affected population estimates.

II Background

A. Current program

The current Low-cost Drugs for the Elderly Program is established in Title 22, section 254 of the Maine Revised Statutes. (See Appendix C.) The Department of Human Services is authorized to conduct a program to provide low-cost prescription and non-prescription drugs, medication and medical supplies to disadvantaged, elderly individuals. The Commissioner has delegated the responsibility for administering the program to the Bureau of Medical Services. The Bureau of Medical Services also administers the Medicaid program in Maine. This connection is important in the administration of the prescription drug program.

Eligibility status of individuals is determined by the State Tax Assessor pursuant to Title 36, chapter 905 of the Maine Revised Statutes. (See Appendix C.) Application for a "drug card" is made on a combined form that allows Maine residents to apply for the property tax refund program, the rent refund program and the elderly low-cost drug program simultaneously. The Maine Revenue Services (formerly Bureau of Taxation) processes all applications as if a person applying for one of the programs is applying for all. If an applicant meets the age and income requirements, a drug card is issued and mailed to the applicant. In calendar year 1996, the Bureau of Taxation processed 56,473 applications; 16,249 applicants were issued drug cards. The number of applications processed in 1997 through November 26 was 44,168; 13,671 drug cards had been issued by that date.

Age eligibility. The age requirements for the Elderly Low-cost Drug Program are tied to the Maine Residents Property Tax Program, specifically the definition of "elderly household" in Title 36, section 6201. To qualify, an applicant must be either 62 years old or part of a household where one person is at least 62 years old. An applicant who is disabled qualifies if at least 55 years old and receiving federal disability payments; if married, one spouse must be at least 55 years old and both must be receiving federal disability payments.

Income eligibility. The income limitations are also tied to the Maine Residents Property Tax Program. Title 36, section 6206 sets income ceilings for single-member elderly households and elderly households with 2 or more members. The statutory amounts were last set by the Legislature in 1987. The State Tax Assessor is required to determine the "household income eligibility adjustment factor" every year to determine the appropriate increase in the income limitations. The State Tax Assessor ties the adjustment factor to the cost of living figure issued by the federal Social Security Administration each October. The income levels are multiplied by the adjustment factor, and the result rounded to the nearest $100, to arrive at the applicable income limitation for that year. The income limitation is increased by 25% for households that have spent at least 40% of the household income on unreimbursed direct medical expenses for prescription drugs.

For 1996, the income limitations were as follows:

Household size	Maximum income
Claimant lives alone	$10,300
Claimant married or with dependents	$12,700
Claimant lives alone, at least 40% of income spent on prescription drugs	$12,875
Claimant married or with dependents, at least 40% of income spent on prescription drugs	$15,875

Diagnoses. The Elderly Low-cost Drug Program pays for drugs to treat illnesses. The law specifically requires the inclusion of prescription drugs used for the treatment of obstructive lung disease (asthma), and it must include antiarthritic drugs and anticoagulant drugs (blood thinners). The program also covers diabetes and cardiac medications. The statute does not specify which drugs are covered and this allows the Bureau of Medical Services to keep the program current as treatment changes, new drugs come on the market and medical science progresses. The Bureau determines which medications are approved for each diagnosis covered by keeping current with the generally accepted medical use, gleaned from review of the peer literature, current medical practice and the federal Food and Drug Administration. A listing of the covered medications as of November 19,1997 is included in Appendix D.

Copayment. A person holding a drug card issued under the Elderly Low-cost Drug Program presents the card to the pharmacist at the time the prescription is filled. If the medication is prescribed for a covered diagnosis, the participant need pay only $2 or 20% of the usual price, whichever is greater, for the medication. For some medications, this is a significant savings to the participant.

Financing. The Elderly Low-cost Drug Program is financed completely through state funds. Actual expenditures totaled $3,643,259 and $3,453,484 for Fiscal Years 1995-96 and 1996-97 respectively. The program has been appropriated $3,994,328 and $4,126,141 for Fiscal Years 1997-98 and 1998-99 respectively. The Bureau of Medical

Services' administrative costs for this program are absorbed by the Medicaid program, also run by the Bureau.

Drug Rebate Program. The prescription drug program does not cover drugs from manufactures that do not participate in the drug rebate program. Under the rebate program, the State enters into a contract with each individual drug manufacturer who agrees to sell a particular drug in the State at the lowest cost the manufacturer sells the drug to anyone. This is the same arrangement that is used for the Medicaid program. By combining the Elderly Low-cost Drug Program with the Medicaid program in terms of medication volume, the State is able to contract for a large quantity of medications at the lowest possible price.

In simplified terms, the Elderly Low-cost Drug Program and the rebate program work as follows:

- The consumer presents a prescription for a covered medication to the pharmacist, along with the drug card.
- The pharmacist fills the prescription and collects the appropriate copayment amount.
- The pharmacist then bills the State for the difference between the agreed-upon selling price for that medication (plus a dispensing fee) and the copayment actually collected.
- The State reimburses the pharmacy on a quarterly basis.
- The State then informs the manufacturer the amount of that medication prescribed and filled under the program, and the manufacturer reimburses the State for the agreed amount of the rebate.

The average savings for the State is about 19% due to the rebate program. The rebate funds received by the State are deposited back into the fund to pay for more prescription drugs. The result: In Fiscal Year 1996-97, the State paid out $3,453,484 for about $4,316,855 worth of drugs: the value of the rebate was over $833,000. (These figures do not factor in the copayment paid by program participants.) The Bureau of Medical Services has contracted with Goold Health Systems to process the pharmacist claims and handle the reimbursement and rebate procedures.

Participation. The Bureau of Medical Services estimates that there are currently 21,621 Maine residents who are eligible for the Elderly Low-cost Drug Program . Maine Revenue Services indicates that 13,671 cards were issued through November 26, 1997. Only approximately 9,200 have used the card to date. The size of this gap is at least partly due to the fact that drug cards are issued automatically by the Maine Revenue Services to eligible applicants for the Maine Residents Property Tax Program. Another reason eligible residents may not be using the program is that some people who have been issued cards do not require medication covered by the program. This may be because they require no medication or because they are prescribed medication for illnesses other than those covered by the program. Another reason that card holders may not be using the program is that some people have other prescription drug coverage, such as Medicaid or private insurance. The Elderly Low-cost Drug Program is the payor of last resort, meaning it will pick up the cost of covered prescription drugs only if there is no other insurance coverage.

B. Other programs

1. Medicaid.

Federal money funds roughly 2/3 of the Medicaid program in Maine, the remainder coming from the General Fund and the hospital assessment tax. The total Medicaid expenditure in Maine for FY 97 was $1.1 billion. The Medicaid program consists of two main components, a "categorically needy" program and a "medically needy" program. The blind, the disabled, the elderly, pregnant women and families with children are eligible under the categorically needy program. To qualify for Medicaid, these persons must have income (pegged to the federal poverty level for a household of that size) and assets below a certain level. (Appendix E contains federal poverty levels.) A significant portion of the Medicaid budget pays for prescription drugs, with a large part funding drugs for the elderly, either institutionalized or at home. Medicaid coverage is not limited to specific diagnoses, and the copayment is very small.

2. Medicare coverage

Medicare is available to an individual who is 65 or older, worked for at least 10 years in Medicare-covered employment, and is a United States citizen or a permanent resident. Younger people may also qualify for coverage if they have a disability or chronic kidney disease. Medicare is divided into two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance). Medicare Part A is available to anyone 65 or older who qualifies for social security benefits. It covers part of the costs of inpatient hospital care, limited care received in a Medicare-certified skilled nursing facility, home health care and hospice care. Part B Medicare charges an individual a premium and has a deductible. Among the items it covers are doctor's visits and laboratory tests, outpatient hospital services, medical equipment, ambulance service, mammography services, and limited coverage for dental surgery and services of a chiropractor, podiatrist and optometrist. Among the items not covered by Medicare are prescription drugs.

3. Private insurance

Medicare recipients can choose to purchase private supplemental Medicare insurance policies, known as "Medigap" policies, to provide them with additional insurance coverage for medical services not covered by Medicare, including prescription drugs. As of June 1992, federal law mandates that all new Medigap policies must match one of ten standardized benefit plans which are labeled A through J. Regardless of the insurance company the plan is purchased from, the coverage each of the ten plan offers is identical from company to company. Only three of these Medigap policies offer a prescription drug benefit. Plan J offers the highest amount of prescription drug coverage. This plan covers up to a total of

$3,000 per year after a $250 deductible, and the premiums are up to $300 per month.

Massachusetts is one of only three states that is not required to follow Medigap guidelines. Massachusetts had already standardized its Medigap insurance before the federal legislation was enacted; as a result, the state was not required to change its Medigap plans. The Department of Professional and Financial Regulation, Bureau of Insurance is reviewing the Massachusetts experience with expanded Medigap prescription drug coverage.

4. New York's EPIC

Since 1977, eleven states have created pharmaceutical assistance programs to provide non-Medicaid low- and moderate-income elderly persons with financial help in paying for prescription drugs. These programs vary widely in their design and costs. There are also wide differences among state programs in the range of medications covered, copayment amounts and income eligibility limits.

New York's Elderly Pharmaceutical Insurance Coverage Program (EPIC) was implemented in October of 1987. The EPIC program establishes two separate categories of participants. Low cost comprehensive coverage is available for elderly with lower incomes. For the elderly with moderate incomes, catastrophic coverage is available, but requires a higher premium or an annual deductible to join. The program enrollment fee is based on the income of the applicant. Currently, New York State residents are eligible for EPIC if they are 65 or older, with annual incomes up to $18,000 if single and $21,000 if married. The copayment charge ranges from $6 to $15 for each prescription, based on the participant's income. It was reported that in 1993, EPIC saved more in hospital and nursing home costs than the State of New York spent on the program. (EPIC Evaluation Report to the Governor and Legislature: Maintaining Health, Dignity and Independence, 1987-1995)

Although EPIC has been rated as successful by its participants, enrollment in the program has been below projections since its start-up in 1987. Several barriers to program participation have been identified. They include: the program's complicated structure; a lack of understanding of the program's eligibility criteria and deductible requirements; and the program's entry cost. To improve participation in the program, an extensive outreach effort was made to enroll seniors in the program. These efforts included mailers to seniors who had a high probability of being eligible; explaining the program to seniors at community events statewide; and establishing a toll-free hotline. Other recommendations for expanding program participation included periodic distribution of EPIC information to seniors participating in other assistance programs and an increased involvement of health care providers.

III Findings

Members of the Task Force have identified the following inadequacies in the existing Elderly low-cost Drug Program.

A. Lack of public knowledge

The Bureau of Medical Services estimates that the number of residents of the State eligible to participate in the program to be 21,621; the Maine Revenue Services has issued 13,671 cards through November 26, 1997, and only about 9,200 have used the card this calendar year. The Task Force believes that some eligible residents are simply unaware that the program exists or that it may be of benefit to them.

B. Serious illnesses and conditions not covered

The Task Force discussed the fact that although the diagnoses currently covered by the program are chronic illnesses that require medication on a regular basis, there are other serious illnesses that meet that description that are not covered. One category of prescription drugs that was mentioned several times are medications to treat high cholesterol levels. The Task Force also expressed concern that the organ transplant population of Maine has few options for assistance in paying for necessary anti-rejection medication.

C. Age limitation

Some members of the Task Force believe that prescription drug coverage begins too late. By limiting eligibility to those 62 and older (the age threshold is 55 for those who are disabled), the health of some older residents may have already deteriorated to the point where they have ceased being productive members of the workforce. By starting coverage later than the onset of some health problems, the costs for treating those conditions becomes much greater, and the persons are in worse health when they become eligible for the program.

On the other hand, it was noted that generally there are more illnesses affecting people at 65 than at 62, and covering more medications but at a higher threshold age may help a broader category of people.

D. Income limitations are too low

There was some discussion that the income limitations are too low, especially for older residents who have one or more medical conditions that require medication on a

regular basis. As currently set, the income ceilings are around 130% of the federal poverty guidelines for a family of one, and 120% for a family of two.

E. Significant prescription drug costs may not be covered

Although the Task Force has no statistics to determine how many residents are faced with this problem, there is concern that older persons with incomes above the thresholds do not qualify, even if the amounts they pay for prescription drugs are so large that their incomes, reduced by their medication costs, would bring them below the income limitations.

F. Leap frog income eligibility

A concern noted by the Maine Revenue Services and others is the problem of "leap frog eligibility." The Elderly low-cost Drug Program includes an increased income limitation for households that spend at least 40% of the household income on prescription drugs that aren't otherwise covered by insurance. A resident who is eligible this year because of the large outlay for prescription drugs last year may not qualify next year because this year's prescription drug costs consist of only the copayments. Without a drug card next year, the person's prescription drug costs will again exceed 40% of the household income, making the person eligible for the program the following year.

IV Recommendations

A. Information from the Bureau of Medical Services

Because the members of the Task Force recognized that the success of recommendations for improving access to the Elderly low-cost Drug Program would be tied to the financial cost, the Task Force requested that the Bureau of Medical Services provide information concerning the numbers of people affected and the projected costs associated with modifying the Elderly low-cost Drug Program in different ways. In general, the Bureau was asked to provide information based on expanding the program by:

- Increasing the income limitations to higher percentages of the federal poverty guidelines
- Lowering the minimum age to 60, 55 or 50
- Covering additional illnesses and conditions, specifically:
    - HIV
    - cholesterol
    - osteoporosis

- incontinence
- thyroid
- Parkinson's Disease
- glaucoma
- Multiple Sclerosis
- Amyotrophic lateral sclerosis (ALS)
- Hodgkin's disease
- cancer
- transplants

The Bureau performed a series of complicated calculations, based on several assumptions and models of population and drug utilization. The spreadsheets containing the results are included as Appendix F.

B. Recommendations

The Task Force's recommendations are as follows. The legislation implementing the recommendations is included in Appendix G.

1. Public education and outreach about the program

There should be improved public education about the Elderly Low Cost Drug Program, and outreach efforts should be increased. Specifically:

- Information should be included with the drug card when it is mailed to the eligible recipient. The Bureau of Medical Services should prepare an easy to read brochure with telephone numbers and other sources for more information about the program. The Bureau should provide the brochures to the Maine Revenue Services for inclusion in the mailings.

- The Bureau of Medical Services should develop posters explaining the benefits of the program, who is eligible and how to take advantage of the program. These posters should be furnished to pharmacies, the Area Agencies on Aging and other senior citizen service providers.

- The Bureau of Medical Services should develop flyers that are appropriate for pharmacists to include in the bag along with the customer's prescription drug purchase. The flyers should provide information about the program, including how to apply for the benefits.

2. Expand coverage through a Medicaid waiver

The Department of Human Services should seek a waiver from the Health Care Financing Authority to provide Medicaid prescription drug coverage for all Maine residents who are 62 years of age or older and whose income is not more than 185% of the federal poverty level. The actual income limit should be flexible as estimates dictate in order to approximate long term cost neutrality. Cost neutrality is based on the fact that access to prescription drugs for the elderly decreases the need for institutionalization of those same people. The decrease is not immediate; a one- to two-year lead time is anticipated before the expenditures for nursing home and other institutional care go down because improved health due to the availability of prescription drugs.

The current estimate is that at the current federal Medicaid match rate, and pursuant to a HCFA waiver, a prescription drug for the elderly program could cover all residents 62 years of age and over whose income is not more than 185% of the federal poverty level for an additional cost to the State of approximately $7.3 million. The estimates and calculations, in comparison to coverage for those 65 and over, are shown in the following chart.

Drug Costs of Expanding the DEL Program to Equal the Medicaid Drug Program

Age:	62 and +	65 and +
Federal Poverty Level:	185%	185%
Eligible/participating population (assuming 75% utilization rate)	32,141	27,837
Capitated cost per person (aged, noninstitutionalized rate)	$1,138	$1,138
Total capitated cost	$36,576,458	$31,678,506
Less drug rebate (about 18%)	($6,583,763)	($5.702,132)
Total costs	$29,992,695	$25,976,374
State match (cost X 33.69%)	$10,104,538	$8,751,440
Less current cost (includes deduction for capitated disabled and age 55-64 under DEL)	~$2,800,000	~$2,800,000
NET COST	---------- **$7,304,538**	---------- **$5,951,440**

These figures are based on preliminary estimates. The final Task Force recommendation may change slightly to take advantage of more accurate population and cost figures as the Bureau refines its estimates and projections.

The Task Force acknowledges inflation in the costs of drugs, and that new, more expensive and more complex drugs are developed and come on the market at a regular pace. This will increase the money spent on prescription drugs on a regular basis. By the same token however, nursing home costs will continue to increase, and illnesses that give patients no option but to become nursing home residents today may be treated with new drugs tomorrow that will keep them healthier and allow them to stay in their own homes. The cost of the new therapies will still be less than the costs of institutionalizing our older population. The Bureau of Medical Services estimated that it spent $203 million in 1997 for nursing home care.

Even more important than the financial aspects is the improved quality of life that access to prescription drugs can provide Maine's elderly. Helping older residents stay healthier and productive participants in the community results in benefits shared by all.

The Task Force requests that the Bureau of Medical Services report to the Joint Standing Committee on Health and Human Services regularly between now and the end of the Second Regular Session of the 118th Legislature regarding the progress of the Medicaid waiver application. The Task Force supports adjustments to the 185% goal as necessary.

3. Interim expansion

Because the Medicaid waiver process is lengthy, the Task Force recommends that the Low-cost Drugs for the Elderly Program be expanded in the interim. The Task Force supports expansion based on the same General Fund obligation that will be necessary for the Medicaid waiver recommended above. Although the members do not have strong feelings as to whether the program should be expanded by increasing the income limits or by covering more medications or both, the members made a recommendation at the Task Force's last meeting for increasing the income limits to 185% of the federal poverty level This recommendation is subject to change based on the additional figures the Bureau of Medical Services is able to provide. Preliminary calculations estimate that the entire new $7.3 million would be necessary to cover that additional population. That amount of increased funding would not cover additional drugs, or a lower age threshold. Draft legislation carrying out this recommendation is included in Appendix G. It should be noted that the Task Force may support a different mix of expansion should the Bureau's figures indicate that the benefits would be greater if the income limit were raised to only 150% but additional categories of

medication were covered. At this point, the Task Force expresses no preference for which medications should be covered under the expanded program.

4. Insurance issues

The Task Force became aware in the process of exploring access to prescription drugs for the elderly that there is a serious problem for organ transplant patients and their families in affording the life-sustaining anti-rejection drugs that are required for the rest of the transplant patient's life. Once transplant patients reach the age of 65 and rely on Medicare benefits, their anti-rejection drugs are not covered. The Task Force recommends that both the Joint Standing Committee on Banking and Insurance and the Joint Standing Committee on Health and Human Services investigate the problem of unavailability of affordable insurance coverage for transplant patients' prescription drugs. One specific area that the Task Force suggests the two committees examine is the impact of Public Law 1997, chapter 370 on this issue. This law was passed during the 117th Legislature, First Special Session; it enacted a new provision in the Community Rating Law that allows insurance companies to set a separate community rate for guaranteed renewable individual policies of Medicare eligible recipients. The Task Force recommends that the Bureau of Insurance continue to research the issue and, in conjunction with the two committees, develop a method of addressing the problem. A copy of the letters to the committees and the Bureau are contained in Appendix H.

CHAPTER 560

H.P. 1357 - L.D. 1904

An Act to Discourage Smoking, Provide Tax Relief and Improve the Health of Maine Citizens

Be it enacted by the People of the State of Maine as follows:

. . .

PART E

Sec. E-1. Task Force on Improving Access to Prescription Drugs for the Elderly established. The Task Force on Improving Access to Prescription Drugs for the Elderly, referred to in this Part as the "task force," is established.

Sec. E-2. Membership. The task force consists of 9 members appointed as follows:

1. Three members, appointed by the President of the Senate;

2. Three members, appointed by the Speaker of the House of Representatives; and

3. Three members, appointed by the Governor.

The chair of the task force must be selected jointly from the members by the President of the Senate, the Speaker of the House of Representatives and the Governor.

Sec. E-3. Appointments. All appointments must be made no later than 30 days following the effective date of this Part. The appointing authorities shall notify the Executive Director of the Legislative Council upon making their appointments. When the appointment of all members is complete, the Executive Director of the Legislative Council shall call and convene the first meeting of the task force no later than October 10, 1997.

Sec. E-4. Duties. The task force shall determine and recommend methods on improving access to prescription drugs for the State's elderly citizens.

Sec. E-5. Staff assistance. The task force may request staffing and clerical assistance from the Legislative Council.

Sec. E-6. Compensation. Members of the task force who are Legislators are entitled to receive the legislative per diem, as defined in the Maine Revised Statutes, Title

3, section 2, and reimbursement for travel and other necessary expenses for each day's attendance at meetings of the task force. Other members of the task force are not entitled to compensation or reimbursement for expenses.

Sec. E-7. Report. The task force shall submit its recommendations, with any necessary implementing legislation, to the Governor and the Legislature by January 15, 1998. The Joint Standing Committee on Health and Human Services may report out legislation based on the report of the task force.

Sec. E-8. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	1997-98
LEGISLATURE	
Task Force on Improving Access to Prescription Drugs for the Elderly	
Personal Services	$1,320
All Other	1,700
Provides funds for the per diem and expenses of legislative members and for miscellaneous costs, including printing of the Task Force on Improving Access to Prescription Drugs for the Elderly.	
LEGISLATURE TOTAL	$3,020

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TASK FORCE ON IMPROVING ACCESS TO PRESCRIPTION DRUGS FOR THE ELDERLY
(Chapter 560, P.L. 1997, Part E)
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TITLE 22
SUBTITLE 2
HEALTH

PART 1
ADMINISTRATION

CHAPTER 101
GENERAL PROVISIONS

22 § 254. Elderly low-cost drug program

The Department of Human Services may conduct a program to provide low-cost prescription and nonprescription drugs, medication and medical supplies to disadvantaged, elderly individuals. In any year in which this program is conducted, it must include any prescription drugs used for the treatment of chronic obstructive lung disease.

In any year in which this program is conducted, it must include antiarthritic drugs.

In any year in which this program is conducted, it must include anticoagulant drugs.

The commissioner shall provide for sufficient personnel to ensure efficient administration of the program. The extent and the magnitude of the program shall be determined by the commissioner on the basis of the calculated need of the recipient population and the available funds. The department may not spend more on this program than is available through appropriations from the General Fund, dedicated revenue, federal or other grants and other established and committed funding sources. The commissioner may accept, for the purposes of carrying out this program, federal funds appropriated under any federal law relating to the furnishing of free or low-cost drugs to disadvantaged, elderly individuals and may take such action as is necessary for the purposes of carrying out that federal law and may accept from any other agency of government, individual, group or corporation such funds as may be available to carry out this chapter.

The commissioner may adopt rules relating to the conduct of this program. These rules shall be promulgated in accordance with the Maine Administrative Procedure Act, Title 5, chapter 375, and shall be related to the following aspects of this program:

1. Prescription and nonprescription drugs. The kinds of prescription and nonprescription drugs, medications and medical supplies which may be made available through the operation of this program;

2. Individuals eligible for participation. Eligibility status of individuals shall be determined by the State Tax Assessor pursuant to Title 36, chapter 905;

3. Specifications for administration of program. Specifications for the administration and management of the program which may include, but not be limited to, program objectives, accounting and handling practices, supervisory authority and evaluation methodology;

4. Method of prescribing or ordering drugs. The method of prescribing or ordering these drugs, which may include, but is not limited to, the use of standard or larger prescription refill sizes so as to minimize operational costs and to maximize economy. Unless the prescribing physician indicates otherwise, the use of generic or chemically equivalent drugs is required, provided that these drugs are of the same quality and have the same mode of delivery as is provided to the general public, consistent with good pharmaceutical practice. Each prescription filled must be for a supply of 90 days unless the prescribing physician or the recipient requests otherwise;

4-A. Payment for drugs provided. The commissioner may establish the amount of payment to be made by recipients toward the cost of prescription or nonprescription drugs, medication and medical supplies furnished under this program provided that the total cost for any covered purchase of a prescription or nonprescription drug or medication does not exceed 20% of the price allowed for that prescription under program rules or $2, whichever is greater. If a recipient is prescribed a drug in a quantity specifically intended by the provider or pharmacist, for the recipient's health and welfare, to last less than one month, only one payment for that drug for that month is required;

4-B. Limitation. (repealed)

5. Other rules. Such other rules as may be necessary to efficiently and effectively manage and operate a program within the intent of this section.

6. Establish a planned program. (repealed)

7. Wholesale price. Wholesale price means the average price paid by a wholesaler to a pharmaceutical manufacturer for a product distributed for retail sale. Wholesale price includes a deduction for any customary prompt payment discounts.

8. Drug rebate program. Effective May 1, 1992, payment must be denied for drugs from manufacturers that do not enter into a rebate agreement with the department for prescription drugs included in the list of approved drugs under this program. Each agreement must provide that the pharmaceutical manufacturer make rebate payments to the department according to the following schedule.

A. For the period beginning May 1, 1992 and ending September 30, 1992, the rebate percentage is equal to 11% of the manufacturer's wholesale price for the total number of dosage units of each form and strength of a prescription drug that the department reports as reimbursed to providers of prescription drugs, provided payments are not due until 30 days following the manufacturer's receipt of utilization data supplied by the department, including the number of dosage units reimbursed to providers of prescription drugs during the period for which payment is due.

B. For the quarters beginning October 1, 1992, the rebate percentage is equal to the percentage recommended by the federal Health Care Financing Administration of the manufacturer's wholesale price for the total number of dosage units of each form and strength of a prescription drug that the department reports as reimbursed to providers of prescription drugs, provided payments are not due until 30 days following the manufacturer's receipt of utilization data supplied by the department, including the number of dosage units reimbursed to providers of prescriptions drugs during the period for which payments is due.

Upon receipt of data from the department, the pharmaceutical manufacturer shall calculate the quarterly payment. If a discrepancy is discovered, the department may, at its expense, hire a mutually agreed-upon independent auditor to verify the pharmaceutical manufacturer's calculation. If a discrepancy is still found, the pharmaceutical manufacturer shall justify its calculation or make payment to the department for any additional amount due. The pharmaceutical manufacturer may, at its expense, hire a mutually agreed-upon independent auditor to verify the accuracy of the utilization data provided by the department. If a discrepancy is discovered, the department shall justify its data or refund any excess payment to the pharmaceutical manufacturer.

If the dispute over the rebate amount is not resolved, a request for a hearing with supporting documentation must be submitted to the Administrative Hearings Unit. Failure to resolve the dispute may be cause for terminating the drug rebate agreement and denying payment to the pharmaceutical manufacturer for any drugs.

All prescription drugs of a pharmaceutical manufacturer who enters into an agreement pursuant to this subsection that appear on the approved list of drugs must be immediately available and the cost of the drugs must be reimbursed and is not subject to any restrictions or prior authorization requirements. Any prescription drug of a manufacturer that does not enter into an agreement is not reimbursable unless the department determines the prescription drug is essential. The department shall seek a manufacturer's rebate for pharmaceuticals used in the Maine Health Program.

TITLE 36
CHAPTER 905
CERTIFICATION OF ELIGIBILITY FOR ELDERLY LOW COST DRUG PROGRAM

36 § 6161. Purpose

The purpose of this chapter is to determine and certify the eligibility status of individuals for the elderly low cost drug program.

36 § 6162. Eligibility criteria; appeal (REPEALED)

36 § 6162-A. Eligibility; definitions; appeal

Individuals are eligible for this program if they meet the following conditions.

1. Age. Individuals qualify under this program if they meet the age requirements for an elderly household under chapter 901 and its successors.

2. Income. Eligibility for this program is determined by the same income levels as eligibility for elderly households is determined under chapter 907, except that individuals are also eligible for this program if the household spends at least 40% of its income on unreimbursed direct medical expenses for prescription drugs and the household income is not more than 25% higher than the levels specified in chapter 907.

3. Residence. An individual must be a legal resident of this State at the time the application is filed.

4. Limitation. An individual does not qualify under this program if receiving state supplemental income benefits.

5. Definitions. As used in this chapter, unless the context clearly indicates otherwise, all terms have the same meaning as in chapter 901 and its successors.

6. Adjustment. The income limitations provided in this section shall be adjusted annually in the same manner as provided in chapter 901 and its successors.

7. Appeals. The eligibility decision, made by the State Tax Assessor or his designee, shall be final, subject to appeal in accordance with the Maine Administrative Procedure Act, Title 5, chapter 375.

36 § 6163. Administration

The State Tax Assessor shall make available suitable applications with instructions for applicants. The State Tax Assessor shall accept applications for eligibility throughout the year and no application may be denied on the basis that it was not submitted before a deadline set by the State Tax Assessor.

36 § 6164. Certification

The State Tax Assessor shall annually issue an identification certificate to eligible applicants. The certificate shall be valid for the 15-month period beginning October 1st of the current calendar year through December 31st of the following year.

CHAPTER 901
THE ELDERLY HOUSEHOLDERS TAX AND RENT REFUND ACT

(repealed PL 1987, c. 516)
(replaced by Chapter 907)

CHAPTER 907
MAINE RESIDENTS PROPERTY TAX PROGRAM

36 § 6201. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Benefit base. "Benefit base" means property taxes accrued or rent constituting property taxes accrued. In the case of a claimant paying both rent and property taxes for a homestead, benefit base means both property taxes accrued and rent constituting property taxes accrued.

2. Claimant. "Claimant" means an individual who has filed a claim under this chapter and was domiciled in this State and occupied a homestead in this State during the entire calendar year preceding the year in which claim for relief under this chapter is filed. Regardless of how many names of individuals appear on the property deed, the person who meets the qualifications described in this subsection and proves sole responsibility for the payment of the property taxes on the subject property is the claimant for that property. If 2 or more individuals meet the qualifications in this subsection and share the payment of

the rent or the responsibility for the payment of the property taxes, each individual may apply on the basis of the rent paid or the property taxes levied on the homestead that reflect the ownership percentage of the claimant and the claimant's household.

If 2 or more individuals claim the same property, the matter must be referred to the State Tax Assessor whose decision is final. Ownership of a homestead under this chapter may be by fee, by life tenancy, by bond for deed, as mortgagee or any other possessory interest in which the owner is personally responsible for the tax for which a refund is claimed.

3. Elderly household. "Elderly household" means a household in which:

A. At least one member of the household has attained the age of 62 during the year for which relief is requested;

B. The claimant is currently not married and has attained the age of 55 during the year for which relief is requested and is, due to disability, receiving federal disability payments, such as supplemental security income; or

C. The claimant is currently married and has attained the age of 55 during the year for which relief is requested and both the claimant and the claimant's spouse are, due to disability, receiving federal disability payments, such as supplemental security income.

4. Gross rent. "Gross rent" means rental paid at arm's length solely for the right of occupancy of a homestead, exclusive of charges for any utilities, services, furniture, furnishings or personal property appliances furnished by the landlord as part of the rental agreement, whether or not expressly set out in the rental agreement. If the landlord and tenant have not dealt with each other at arm's length, and the State Tax Assessor is satisfied that the gross rent charged was excessive, the State Tax Assessor may adjust the gross rent to a reasonable amount for purposes of this chapter.

5. Homestead. "Homestead" means the dwelling owned or rented by the claimant or held in a revocable living trust for the benefit of the claimant and occupied by the claimant and the claimant's dependents as a home, and may consist of a part of a multidwelling or multipurpose building and a part of the land, up to 10 acres, upon which it is built. "Owned" includes a vendee in possession under a land contract and of one or more joint tenants or tenants in common.

6. Household. "Household" means a claimant and spouse and members of the household for whom the claimant under this chapter is entitled to claim an exemption as a dependent under Part 8 for the year for which relief is requested.

7. Household income. "Household income" means all income received by all persons of a household in a calendar year while members of the household.

8. Household income eligibility adjustment factor. "Household income eligibility adjustment factor" means one plus the annualized cost-of-living adjustments for Social Security retirement benefits during the year for which relief is requested.

9. Income. "Income" means the sum of Maine adjusted gross income determined in accordance with Part 8, the amount of capital gains excluded from adjusted gross income, the absolute value of the amount of trade or business loss, net operating loss carry-over, capital loss, rental loss, farm loss, partnership or S Corporation loss included in adjusted gross income, alimony, inheritance, life insurance proceeds paid on death of insured, nontaxable lawsuit rewards, such as slander, libel and pain and suffering, excluding reimbursements such as medical and legal expenses associated with the case, support money, nontaxable strike benefits, the gross amount of any pension or annuity, including railroad retirement benefits, all payments received under the federal Social Security Act, state unemployment insurance laws, veterans' disability pensions, nontaxable interest received from the Federal Government or any of its instrumentalities, interest or dividends on obligations or securities of this State and its political subdivisions and authorities, workers' compensation and the gross amount of "loss of time" insurance, cash public assistance and relief, but not including relief granted under this chapter. Income does not include the first $5,000 in the proceeds from a life insurance policy, whether paid in a lump sum or in the form of an annuity. Income also does not include gifts from nongovernmental sources or surplus foods or other relief in kind supplied by a governmental agency.

10. Property taxes accrued. "Property taxes accrued" means property taxes exclusive of special assessment, delinquent interest and charges for service levied on a claimant's homestead in this State as of April 1, 1972, or any tax year thereafter. If a homestead is owned by 2 or more persons or entities as joint tenants or tenants in common, and one or more persons or entities are not members of the claimant's household, "property taxes accrued" is that part of property taxes levied on the homestead that reflects the ownership percentage of the claimant and the claimant's household. If a claimant and spouse own their homestead for part of the year for which relief is requested and rent it or a different homestead for part of the same tax year, "property taxes accrued" means taxes levied on the homestead on April 1st, multiplied by the percentage of 12 months that the property was owned and occupied by the household as its homestead during the year for which relief is requested. When a household owns and occupies 2 or more different homesteads in this State in the same tax year, property taxes accrued relate only to that property occupied by the household as a homestead on April 1st. If a homestead is an integral part of a larger unit such as a farm, or a multipurpose or multidwelling building, property taxes accrued are that percentage of the total property taxes accrued that the value of the homestead is of the total value, except that property taxes accrued do not include any portion of taxes claimed as a business expense for federal income tax purposes. For purposes of this chapter, "unit" refers to the parcel of property separately assessed of which the homestead is a part.

11. Rent constituting property taxes accrued for an elderly household. "Rent constituting property taxes accrued for an elderly household" means 25% of the gross rent actually paid in cash or its equivalent in any tax year by a claimant and the claimant's household solely for the right of occupancy of their Maine homestead in the tax year and which rent constitutes the basis, in the succeeding calendar year, of a claim for relief under this chapter by the claimant.

11-A. Rent constituting property taxes accrued for nonelderly household. "Rent constituting property taxes accrued for nonelderly household" means 15% of the gross rent actually paid in cash or its equivalent in any tax year by a claimant and the claimant's household solely for the right of occupancy of their Maine homestead in the tax year and which rent constitutes the basis, in the succeeding calendar year, of a claim for relief under this chapter by the claimant.

12. Year for which relief is requested. "Year for which relief is requested" means the calendar year preceding that in which the claim is filed. For a claim filed in January of any year, "year for which relief is requested" means the calendar year 2 years preceding that in which the claim is filed.

36 § 6201-A. Short title

This chapter shall be known and may be cited as the "Maine Residents Property Tax Program."

36 § 6202. Claim is personal

The right to file a claim under this chapter is personal to the claimant and does not survive the claimant's death, but the right may be exercised on behalf of a claimant by the claimant's legal guardian or attorney-in-fact. If a claimant dies after having filed a timely claim, the amount thereof must be disbursed to another member of the household as determined by the State Tax Assessor.

If the claimant was the only member of a household, the claim may be paid to the claimant's personal representative, but if one is not appointed within 2 years of the filing of the claim, the amount of the claim escheats to the State.

36 § 6203. Claim to be paid from General Fund

The amount of the claim after certification by the State Tax Assessor may be paid to claimant from the General Fund. No interest may be allowed on any payment made to a claimant pursuant to this chapter.

36 § 6204. Filing date

A claim may not be paid unless the claim is filed with the Bureau of Revenue Services on or after August 1st and on or before the following January 31st.

36 § 6205. One claim per household

Only one claimant per household or homestead per year shall be entitled to relief under this chapter.

36 § 6206. Income limitations for elderly households

A claimant representing an elderly household shall qualify for the following benefits subject to the following income limitations.

1. Single-member elderly households. For single-member elderly households, the benefit shall be calculated as follows:

If household income equals:	The benefit equals:
$ 0 to $6,800	100% of the benefit base up to a maximum of $400
$6,801 to $7,000	75% of the benefit base up to a maximum of $300
$7,001 to $7,200	50% of the benefit base up to a maximum of $200
$7,201 to $7,400	25% of the benefit base up to a maximum of $100

2. Elderly households with 2 or more members. For elderly households with 2 or more members, the benefit shall be calculated as follows:

If household income equals:	The benefit equals:
$ 0 to $8,100	100% of the benefit base up to a maximum of $400
$8,101 to $8,500	75% of the benefit base up to a maximum of $300

$8,501 to $8,800	50% of the benefit base up to a maximum of $200
$8,801 to $9,200	25% of the benefit base up to a maximum of $100

3. Minimum benefit. No claim of less than $5 may be granted.

36 § 6207. Income limitations for nonelderly households

A claimant representing a nonelderly household qualifies for the following benefits subject to the following income limitations.

1. Benefit calculation. For claimants representing a nonelderly household, the benefit is calculated as follows:

A.

A-1. Fifty percent of that portion of the benefit base that exceeds 4% but does not exceed 8% of income plus 100% of that portion of the benefit base that exceeds 8% of income to a maximum payment of $1,000.

2. Income eligibility. Single-member households with household incomes in excess of $25,700 and households with 2 or more members with a household income in excess of $40,000 are not eligible for a benefit.

A.

3. Subsidized housing; special needs payment. A claim may not be granted under this section to claimants:

A. Whose housing costs for the year for which relief is requested were subsidized by government programs that limit housing costs to a percentage of household income.

B. Who are receiving temporary assistance for needy families under Title 22, chapter 1053-B and are eligible for the housing special needs payment pursuant to Title 22, section 3762, subsection 3, paragraph B, subparagraph (6).

4. Minimum benefit. A claim of less than $10 may not be granted.

36 § 6208. Elderly option

If a claimant representing an elderly household would qualify for a larger benefit under section 6207 than he would receive under section 6206, then that claimant may choose to receive the benefit calculated under section 6207.

36 § 6209. Annual adjustment

1. Household limitation adjustment. Beginning March 1, 1989, and annually thereafter, the State Tax Assessor shall determine the household income eligibility adjustment factor. That factor shall be multiplied by the income limitations in section 6206, applicable for the year prior to that for which relief is requested. The result shall be rounded to the nearest $100 and shall apply to the year for which relief is requested corresponding to the year on which the annualized cost of living adjustments were based. Beginning March 1, 1991, the same procedure shall be employed to adjust the income limitation in section 6207, subsection 2.

36 § 6210. Administration

The State Tax Assessor shall make available suitable forms with instructions for claimants. The claim shall be in the form the State Tax Assessor may prescribe and shall be signed by the claimant.

The State Tax Assessor shall include a checkoff to request an application for the Maine Residents Property Tax Program on the individual income tax form. The assessor shall also provide for the option of filing an application for the Maine Residents Property Tax Program using the telefile system established by the assessor.

36 § 6211. Audit of claim

If, on the audit of any claim filed under this chapter, the State Tax Assessor determines the amount to have been incorrectly determined, he shall redetermine the claim and notify the claimant of the redetermination and his reasons for it. The redetermination shall be final unless appealed to the State Tax Assessor within 30 days of notice.

36 § 6212. Denial of claim

If it is determined that a claim is excessive and was filed with fraudulent intent, the claim shall be disallowed in full and, if the claim has been paid the amount paid may be recovered by assessment, and the assessment shall bear interest from the date of payment or credit of the claim, until refunded or paid, at the rate of 1% per month. The claimant in such case, and any person who assisted in the preparation or filing of such excessive claim or supplied information upon which such excessive claim was prepared, with fraudulent intent, commits a Class E crime. If it is determined that a claim is excessive and was negligently prepared, 10% of the corrected claim shall be disallowed, and if the claim has been paid the proper portion of any amount paid shall be similarly recovered by assessment, and the assessment shall bear interest at 1% per month from the date of payment until refunded. Any claimant or spouse with an unpaid liability arising from this section is disqualified from benefits under this chapter.

36 § 6213. Appeal

A denial in whole or in part of relief claimed under this chapter may be appealed in accordance with section 151 and the Maine Administrative Procedure Act.

36 § 6214. Disallowance of certain claims

A claim shall be disallowed, if the State Tax Assessor finds that the claimant received title to his homestead primarily for the purpose of receiving benefits under this chapter.

36 § 6215. Extension of time for filing claims

In case of sickness, absence or other disability, or if, in his judgment, good cause exists, the State Tax Assessor may extend, for a period not to exceed 6 months, the time for filing a claim.

36 § 6216. Protection from loss of benefits

It is the intent of the Legislature that any claim paid under this chapter shall supplement any benefits paid under aid to the aged, blind and disabled or any program which succeeds or supplants it. The Department of Human Services shall take any such action as may be necessary to assure that recipients of aid to the aged, blind and disabled shall continue to receive as high a percentage of their current assistance as may be possible. To carry out this legislative directive, the department shall utilize all the state funds expected to be saved by a reduction in benefits of recipients of aid to the aged, blind and disabled resulting from this chapter to raise the standards of aid to the aged, blind and

disabled at a total cost in state funds equivalent to the savings in state funds which would be expected as a result of this chapter.

Benefits received under this chapter may not be included as income for purposes of any state or municipally administered public benefit program but may be considered for purposes of determining eligibility for abatement under section 841, subsection 2.

These benefits do not duplicate and shall not reduce the amount of any individual's payment under the Temporary Assistance for Needy Families program because those payments are insufficient to meet the total amount of money determined to be needed for housing in accordance with the state standard of need under that program.

36 § 6217. Sunset (REPEALED)

36 § 6218. Readability; application; instructions

The application form and instructions used by applicants for assistance under the Maine Residents Property Tax Program and its successor, if any, shall have a readability score, as determined by a recognized instrument for measuring adult literacy levels, equivalent to no higher than a 6th grade reading level.

36 § 6219. Outreach plan required

The Bureau of Revenue Services shall develop and implement a plan of outreach to ensure that all eligible households are made aware of assistance available under the Maine Residents Property Tax Program and its successor, if any.

36 § 6220. Coordination required

The Bureau of Revenue Services shall seek the advice and cooperation of the Bureau of Elder and Adult Services; the Bureau of Family Indpendence; the Bureau of Child and Family Services; advocates for elderly and low-income individuals; the Maine Literacy Coalition; and other interested agencies and organizations in developing the application form and instruction booklet for the Maine Residents Property Tax Program and the outreach plan required by section 6219.

APPENDIX 1

MAINE DRUGS FOR THE ELDERLY PROGRAM
HEART - HYPERTENSION - DIABETIC DRUGS

CO-PAY $3.00 SINGLE SOURCE BRAND, GENERIC

$5.00 MULTI-SOURCE BRAND

GENERIC NAME	COMMON KNOWN BRAND NAME(S)
HEART - HYPERTENSION - DIABETIC DRUGS	
ACEBUTOLOL HYDROCHLORIDE	SECTRAL
ACETAZOLAMIDE	DIAMOX
ACETOHEXAMIDE	DYMELOR
ACETYLDIGITOXIN	ACYLANID
ALSEROXYLON	RAUWILOID
AMILORIDE HCL & HYDROCHLOROTHIAZIDE, MSD	MODURETIC
AMMONIUM CHLORIDE	TWIN-K
ATENOLOL	TENORMIN
ATENOLAL & CHLORTHALIDONE	TENORETIC
BENDROFLUMETHIAZIDE & RAUWOLFIA SERPENTINA	RAUZIDE
BENZTHIAZIDE	AQUATAG, EXNA
BENZTHIAZIDE & RESERPINE	EXNA-R
BUMETANIDE	BUMEX
BUTABARBITAL HYDROCHLOROTHIAZIDE & RESERPINE	BUTISERPAZIDE
BUTABARBITAL SODIUM & RESERPINE	BUTISERPINE

CAPTOPRIL	CAPOTEN
CAPTOPRIL & HYDROCHLOROTHIAZIDE	CAPOCIDE
CHLORMERODRIN	NEOHYDRIN
CHLOROTHIAZIDE	DIURIL, DIURIGEN
CHLOROTHIAZIDE & RESERPINE	DIUPRES, THIASERP
CHLORPROPAMIDE	DIABINESE
CHLORTHALIDONE	HYGROTON
CHLORTHALIDONE W/RESERPINE	REGROTON, DEMI-REGROTON
CHLORTHALIDONE & CLONIDINE HYDROCHLORIDE	COMBIPRES
CLONIDINE HYDROCHLORIDE	CATAPRES
CRYPTENAMINE	UNITENSEN
CYCLOTHIAZIDE	ANHYDRON
DESERPIDINE	HARMONYL
DESLANOSIDE	CEDILANID-D
DIAZOXIDE	PROGLYCEM
DICHLORPHENAMIDE	DARANIDE
DIGITALIS	PIL DIGIS, DIGIFORTIS
DIGITOXIN	CRYSTODIGIN. PURODIGIN
DIGOXIN	LANOXIN
DIHYDROERGATAMINE MESYLATE & HEPARIN SODIUM	EMBOLEX
DILITIAZEM HCL	CARDIZEM
DISOPYRAMIDE PHOSPHATE	NORPACE

ENALAPRIL MALEATE, MSD	VASOTEC
ETHACRYNATE SOCIUM, MSD	EDECRIN
ERYTHRITYL TETRANITRATE	CARDILATE
ETHOXZOLAMIDE	ETHAMIDE
FUROSEMIDE	LASIX
GITALIN	GITALIGIN
GLIPIZIDE	GLUCOTROL
GLUCAGON	GLUCAGON
GLYBURIDE	DIABETA, MICRONASE
GUANABENZ ACETATE	WYTENSIN
GUANADREL SULFATE	HYLOREL
GUANETHIDINE SULFATE	ISMELIN
GUANFACIDE HCL	TENEX
HYDRALAZINE HCL	APRESOLINE
HYDRALAZINE HYDROCHLORIDE & HYDRO-CHLOROTHIAZIDE	APRESAZIDE, APRESOLINE, ESIDREX
HYDROCHLOROTHIAZIDE	ESIDRIX, LOQUA, THIURETIC
HYDROCHLOROTHIAZIDE & DESERPIDINE	ORETICYL
HYDROCHLOROTHIAZrDE & GUANETHIDINE SULFATE	ESIMIL
HYDROCHLOROTHIAZIDE, HYDRALIZINE HYDROCHLORIDE & RESERPINE	HHR, HRH, SER-AP-ES
HYDROCHLOROTHIAZIDE	HYDROMAL
HYDROCHLOROTHIAZIDE & RESERPINE	AQUASERP,

	HYDROSERPIN
HYDROFLUMETHIAZIDE	DIUCARDIN, SALURON
HYDROFLUMETHIAZIDE & RESERPINE	SALUTENSIN
INDAPAMIDE	LOZOL
INSULIN	ALL BRANDS
ISMITROL INVENEX	MANNITOL
ISOSORBIDE DINITRATE	ISORDIL, SORBITRATE
LABETALOL HYDROCHLORIDE	TRANDATE, NORMODYNE
LIDOCAINE HCL	XYLOCAINE IV
LISENOPRIL	ZESTRIL
MANNITOL HEXANITRATE	NITRANITOL
MANNITOL HEXANITRATE & PHENOBARBITAL	NITRANITOL W/PB
MECAMYLAMINE HYDROCHLORIDE	INVERSINE
MERCAPTOMERIN SODIUM	THIOMERIN
METHAZ0LAMIDE	NEPTAZANE
METHYCLOTHIAZIDE	AQUATENSEN, ENDURON
METHYCLOTHIAZIDE & DESERPIDINE	ENDURONYL, ENDURONYL FORTE
METHYLDOPA	ALDOMET
METHYLDOPA-CHLORTHIAZIDE	ALDOCLOR
METHYLDOPA-HYDROCHLOROTHIAZIDE	ALDORIL
METOLAZONE	DIULO
METOLAZONE	ZAROXOLYN

METOPROLOL TARTRATE	LOPRESSOR
METOPROLOL TARTRATE & HYDROCHLOROTHIAZIDE	LOPRESSOR HCT
MINOXIDIL	LONITEN
NADOLOL	CORGARD
NADOLOL & BENDROFLUMETHIAZIDE	CORZIDE
NIFEDIPINE	PROCARDIA, ADALAT
NITROGLYCERIN	NITRO DISC, TRANSDERM NITRO, PROGINA
PARAGYLINE HYDROCHLORIDE	EUTONYL
PARAGYLINE HYDROCHLORIDE & METHYCLOTHIAZIDE	EUTRON
PAPAYERINE HCL	CERESPAN, DURABID, PAVA, MEAD, PAVABID
PAPAVERINE HCL & PHENOBARBITAL	PAVABID/PB
PENTOIFYLLINE	TRENTAL
PHENFORMIN HYDROCHLORIDE	MELTROL, DBI, DBI-TD
PHENTOLAMINE	REGITINE
PINDOLOL	VISKEN
POLYTHIAZIDE	RENESE
POLYTHIAZIDE & RESERPINE	RENESE-R
PRAZOSIN HYDROCHLORIDE	MINIPRESS
PRAZOSIN HYDROCHLORIDE & POLYTHIAZIDE	MINIZIDE
PROCAINAMIDE HYDROCHLORIDE	PROCAMIDE, PRONESTYL, PROCAN

PROPRANOLOL HYDROCHLORIDE	INDERAL
PROPRANOLOL HYDROCHLORIDE & HYDRO-CHLORATHIAZIDE	INDERIDE
QUINETHAZONE	HYDROMOX
QUINIDINE GLUCONATE	QUINAGLUTE, DURAQUIN
QUINIDINE POLYGALACTURONATE	CARDIOQUIN
QUINIDINE SULFATE	QUINIDEX, CIN-QIN, QUINORA
QUININE SULFATE	QUINAMM
RAUWOLFIA SERPENTINA	RAUDIXIN, RAUVAL
RESCINNAMINE	MODERIL
RESERPIN	SERPATE RESERPOID, SANDRIL, SERPASIL
RESFRPINE & HYDRALAZINE HYDROCHLORIDE	SERPASIL-APRESOLINE
RESERPINE & HYDROCHLOROTHIAZIDE SPIRONOLACTONE	SERPASIL-ESIDRIX ALDACTONE
SPIRONOLACTONE W/HYDROGHLOROTHIAZIDE	ALDACTAZIDE
SYRINGES (INSULIN)	
SYROSINGOPINE & HYOROCHLOROTHIAZIDE	SINGOSERP-ESIDRIX
TIMOLOL MALEATE, MSD	BLOCADREN
TIMOLOL MALEATE & HYDROCHLOROTHIAZIDE, MSD	TIMOLIDE
TOCAINIDE HYCROCHLOROTHIAZIDE, MSD	TONOCARD
TOLAZIMIDE	TOLINASE
TOLBUTAMIDE	ORINASE

TRALNITRATE PHOSPRATE	METAMINE
TRIAMTERENE	DYRENIUM
TRIAMTERENE & HYDROCHLOROTHIAZIDE	DYAZIDE, MAXZIDE
TRICHLORMETHIAZIDE	METAHYDRIN, DIURESE, NAQUA, SPENZIDE
TRICHLORMETHIAZIDE & RESERPINE	METATENSIN. NAQUIVAL
VERAPAMIL HYDROCHLORIDE	CALAN, ISOPTEN
WARFARIN SODIUM	COUMADIN

ARTHRITIC DRUGS

ACETYLSALICYLIC ACID	ZORPRIN, EASPRIN
ALLOPURINOL	ZYLOPRIM
AURANOFIN	RIDAURA
AUROTHIOGLUCOSE	SOLGANOL
AZATHIOPRINE	IMURAN
COLCHICINE	COLCHICINE
DICLOFENAC SODIUM	VOLTAREN
DIFLUNISAL	DOLOBID
ETODOLAC	LODINE
FENOPROFEN CALCIUM	NALFON
FLURBIPROFEN	ANSAID
GOLD SODIUM THIOMALATE	MYOCHRYSINE
HYDROXYCHLOROQUINE SULFATE	PLAQUENIL
IBUPROFEN	RUFEN, MOTRIN

INDOMETHACIN	INDOCIN
KETOPROFEN	ORUDIS
MECLOFENAMATE SODIUM	MECLOMIN
METHOTREXATE	METHOTREXATE
NABUMETOME	RELAFEN
NAPROXEN	ANAPROX, NAPROSYN
PENICILLAMINE	CUPRIMINE
PHENYLBUTAZONE	BUTAZOLIDIN
PIROXICAM	FELDENE
PREDNISONE	DELTASONE
PROBENECID	BENEMID
PROBENECID W/COLCHICINE	COLBENEMID, PROBEN-C
SALSALATE	DISALCID
SULINDAC	CLINORIL
TOLMETIN SODIUM	TOLECTIN, TOLECTIN DS
SALICYLATE COMBINATION	TRILISATE

COPD DRUGS

ALBUTEROL	PROVENTIL, VENTOLIN
AMINOPHYLLIN	
BECLOMETHASONE DIPROPIONATE	BECLOVENT, VANCERIL
BITOLTEROL MESYLATE	TORNALATE

CROMOLYN SODIUM	INTAL, NASAL CROM
ETHYLNOREPINEPHRINE HCL	BRONKEPHRINE
FLUNISOLIDE	AEROBID
IPRATROPIUM BROMIDE	ATROVENT
ISOETHARINE HCL	BRONKOMETER, BRONROSOL
ISOPROTERENOL	ISUPREL, MEDIHALER-ISO
ISOPROTERENOL & PHENYLEPHRINE BITARTRATE	DUO-MEDIHALER
ISOPROTERENOL HCL	NORISODRINE
ISOPROTERENOL HCL & CYCLOPENTAMINE	AEROLONE
ISOPROTERENOL SULFATE & CALCIUM IODIDE	NORISODRINE W/CALCIUM IODIDE
METAPROTERENOL SULFATE	ALUPENT, METAPREL
OXYTRIPHYLLINE	CHOLEDYL
PIRBUTEROL ACETATE	MAXAIR
TERBUTALINE SULFATE	BRETHAIRE BRETHINE
THEOPHYLLINE	CONSTANT-T, RESPBID, SUSTAIRE
THEOPHYLLINE ANHYDROUS	BRONKODDYL, THEO-24
THEOPHYLLINE ANHYDROUS-GUAIFENESIN	THEOLATE, ELIXOPHYLLIN GG
TRIAMCINOLONE ACETONIDE	AZMACORT

NASAL PRODUCTS NOT COVERED.

1997 Federal Poverty Guidelines for All States (Except Alaska and Hawaii) and the District of Columbia

Size of Family Unit	Percent of Federal Poverty Guideline Level				
	100%	125%	133%	150%	185%
1	$7,890	$9,863	$10,494	$11,835	$14,597
2	$10,610	$13,263	$14,111	$15,915	$19,629
3	$13,330	$16,663	$17,729	$19,995	$24,661
4	$16,050	$20,063	$21,347	$24,075	$29,693
5	$18,770	$23,463	$24,964	$28,155	$34,725
6	$21,490	$26,863	$28,582	$32,235	$39,757
7	$24,210	$30,263	$32,199	$36,315	$44,789
8	$26,930	$33,663	$35,817	$40,395	$49,821

For family units with more than 8 members, add $2,720 at 100% for each additional member. (The same increment applies to smaller family sizes also, as can be seen in the figures above.)

Source: *Federal Register*, Vol. 62, No. 46, March 10, 1997, pp. 10856-10859.

TASK FORCE ON
IMPROVING ACCESS TO PRESCRIPTION DRUGS FOR THE ELDERLY

PL 1997, Chapter 560, Part E

Members:

Sen. Chellie Pingree, Chair
Rep. Joseph Brooks
Rep. Robert Cameron
Rep. Joseph Jabar

Jean Deyoe
Roger Hare
John Grotton
John Marvin
Robert Philbrook

February 13, 1998

Senator Lloyd P. LaFountain III, Senate Chair
Representative Jane W. Saxl, House Chair
Joint Standing Committee on Banking and Insurance
118th Maine Legislature

Senator Judy A. Paradis, Senate Chair
Representative J. Elizabeth Mitchell, House Chair
Joint Standing Committee on Health and Human Services
118th Maine Legislature

re: Insurance coverage for organ transplant patients

Dear Sen. LaFountain, Sen. Paradis, Rep. Saxl and Rep. Mitchell:

In the course of our study on improving access to prescription drugs for the elderly, we were dismayed to learn that there is inadequate insurance availability for organ transplants patients. As you may be aware, organ transplant patients require anti-rejection medication for the rest of their lives. Although our Task Force recommendation is to provide coverage for elderly Mainers at or below 185% of the federal poverty level through a Medicaid waiver program, neither the current Elderly Low-cost Drug Program nor Medicare cover anti-rejection medication. We enclose a letter from Alice Knapp of the Bureau of Insurance explaining why the recent amendments to the community rating law have negatively affected transplant patients, thus creating an enormous burden for these patients and their families.

We understand that Massachusetts has adopted legislation requiring additional coverage for prescription drugs. The Bureau of Insurance is continuing to do research on the Massachusetts program, whether it could be implemented in Maine, and whether it makes sense to adopt the program here.

We respectfully request that the Banking and Insurance Committee and the Health and Human Services Committee work with the Bureau of Insurance to develop methods of providing financial assistance or insurance coverage for prescription drugs for organ transplant patients in this State.

Thank you for your work on this issue that is devastating for a growing population in our State.

Sincerely,

Sen. Chellie Pingree
Chair

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enclosure
cc: Maine Congressional delegation
Alice Knapp, Bureau of Insurance